STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an annual Medicare Re-certification survey that was conducted at your facility from August 19 through August 22, 2008. The census at the time of the survey was 174. The sample size was 33, including 3 closed records. The following complaints were investigated: #NV19009 - Unsubstantiated #NV18707 - Unsubstantiated #NV17950 - Substantiated without deficiencies The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		10/7/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1	F 279		

psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to initiate and maintain necessary comprehensive care plans for 2 of 33 residents (#2 and #3).

Findings include:

Resident #2

Record Review

Resident #2 was an 84 year old male resident admitted on 05/22/08 with diagnoses of Dementia, Generalized Weakness, Asphyxia/Hypoxia/Anoxia, Hypertension, Anemia, Malnutrition, Hypoalbuminemia, and Cerebral Infarct.

The Minimum Data Set (MDS) dated 05/29/08, identified the Resident Assessment Protocol (RAP) #6 (Urinary Incontinence) and #7 (Psychological Well-Being) as areas for the resident's care plan development.

No care plan for urinary incontinence was provided for review.

No care plan for psychological well-being was provided for the resident's care prior to 08/22/08.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2	F 279		

On 08/22/08 at 11:20 AM, Employee #3 provided a care plan addressing anti-psychotic and anti-anxiety drug use for Resident #2. The care plan indicated an initiation date of 08/22/08. Employee #3 indicated the care plan was not in the chart and was being initiated. However, the resident was receiving medications (Aricept, Seroquel and Ativan) from the facility without a care plan evidenced by a physician orders dated 07/02/08 (indicated Aricept 5 milligrams nightly), dated 08/01/08 (indicated Seroquel 12.5 milligrams nightly), and dated 08/09/08 (indicated Ativan 0.5 milligrams every 8 hours as needed).

Resident #3

Resident #3 was a 60 year old male admitted on 01/30/08 with diagnoses including Dysphagia, Adult Failure To Thrive, Hypoalbuminemia, Malnutrition, Cerebrovascular Accident, Speech Disturbance, Coronary Disease, Pneumonia, Gastrostomy Tube, and Depression.

Record Review

Initial physician orders indicated a diet of Fibersource HN at 60 milliliters (ml) per hour with 180 ml of water every 6 hours. The rate was changed to 80 ml per hour for 18 hours with 250 ml of water every 8 hours on 01/31/08. The facility maintained these same rates between 01/31/08 and 08/22/08.

Section K of the admission Minimum Data Set (MDS) assessment, dated 02/05/08, indicated the resident had chewing and swallowing problems and weighed 186 pounds. The MDS identified the Resident Assessment Protocol for feeding tubes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3	F 279		

and dehydration/fluid maintenance as areas for the resident's care plan development. The resident's care plan was initiated on 02/08/08, and reviewed on 05/08/08 and 08/08/08. Between 02/08/08 and 08/21/08, the facility did not modify any approaches/interventions in addressing the resident's feeding tube and dehydration/fluid maintenance. All care plan copies contained the same, unmodified care plan approaches/interventions.

Interview

On 08/21/08, at 3:15 PM, Employee #6 indicated the facility initiated weekly weights on 06/06/08. The facility continued weekly weights. She indicated the resident's meal intake decreased from 40% to 10% as of 07/09/08 and increased from 10% to 40% as of 07/30/08. [However, the July 2008 certified nursing assistant flow sheet indicated the meal intake for Resident #3 was 40% only once]. Employee #6 indicated the facility remained in verbal contact with the advanced nurse practitioner (ANP) on a weekly basis, but the facility never notified the doctor because it was easier to notify the ANP. The facility informed the advanced nurse practitioner on 06/18/08, in writing, and the facility received no new orders. Employee #6 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #6 indicated none were written. Employee #6 indicated the facility held weekly weight summary meetings with Employees #2, #5, and #6. Employee #6 indicated approaches were limited to re-weights of spurious weights and continuing weekly weights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4	F 279		

On 08/21/08, at 4:30 PM, Employee #2 indicated Employees #2, #5, and #6 met weekly regarding weekly weight summaries for residents with weight loss. Employee #2 was shown the facility's weight loss policy and the weight record for Resident #3. Employee #2 agreed the facility's policy was to re-weigh residents with questionable weight loss and the facility should have re-weighed Resident #3 after a 15 pound weight loss on 06/01/08. Employee #2 browsed through the weekly weight summaries and the feeding care plan #5 for Resident #3 and indicated the following: The approaches for Resident #3 were limited to weekly weights, pureed diet, and the ANP did not offer suggestions when contacted on 06/18/08. Employee #2 indicated Resident #3's meal intake increased to 40% as of 06/25/08 and as of 07/30/08. [However, both the June 2008 and July 2008 certified nursing assistant flow sheets indicated the meal intake for Resident #3 was 40% once in each month]. Employee #2 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #2 indicated none were written.

On 08/22/08, between 9:00 AM and 9:20 AM, Employee #5 indicated Resident #3 weighed 186 pounds at admission (on 02/03/08) and weighed 165 pounds on 07/23/08 and 162 pounds on 08/22/08. Employee #5 indicated other approaches/interventions, such as increasing the tube feeding, were not considered because Resident #3 was still within the established ideal body weight range between 149 and 183 pounds, although now below the median of 166. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 was also a concern of increasing residuals [even though no residuals were ever documented in the chart]. Employee #5 indicated Employees #2, #5, and #6 met to revise approaches during weekly weight summary meetings. Employee #5 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #5 indicated none were written. Employee #5 indicated approaches/interventions should correspond to problems and that it was her mistake and her responsibility for not listing new approaches/interventions, revising them, and writing new ones.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Physician orders were followed for 2 of 33 residents (#6, #18). Findings include: Resident #6 Resident #6 was a 91 year old female with	F 309		10/7/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 diagnoses including: Dementia; Hypertension; Hypothyroidism; and Diabetes - adult onset. Record Review - On 4/25/08, a Physician order stated, "D/C (discontinue) Synthroid 0.112 mg (milligram). Synthroid 0.88 po (orally) qd (every day)/ Hypothyroid TSH (thyroid lab), FREE T4 (thyroid lab) in 8 weeks." - A Pharmacist Progress note was written on 7/16/08, and stated, "...Synthroid decreased on 4/26 with a follow up TSH/FREE T4 (thyroid labs) ordered in 8 weeks. This should have been done around 6/24. The results are not in the chart. Please f/u (follow up) to ensure they were drawn and place in chart." - The most recent TSH and FREE T4 labs in the residents file were dated 7/20/08. Resident #18 Resident #18 was an 49 year old male with diagnoses including: Sinus Tachycardia; Cerebral Palsy; Seizure Disorder; Resection Brain; Quadriplegia; and Abnormal involuntary Movements. Issue A Record Review - On 7/14/08, a Physician order stated, "ST (speech therapy) evaluation - cough when eating, CXR (chest Xray) CBC (Complete Blood Count). - The most recent laboratory tests (labs) in the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7	F 309		

chart were dated 11/24/07.

Interview

- On 8/22/08, in the morning, the unit nurse confirmed the 11/24/07, lab results in the record were the resident's most recent labs.

Issue B

Record Review

- On 11/9/07, a Physician's order was written for a "Pureed" diet.

- On 12/18/07, a Physician's order stated, "... Continue current diet."

- The most recent (8/2008) Re-capulation orders stated, "Diet: Pureed."

- Weekly Weight Summaries:
8/13/08 - Diet Order: Pureed
8/20/08 - Diet Order: Pureed - Nectar Thick Liquids

- Nutritional Assessments:
5/1/08 - Diet: Pureed and Nectar Liquids and snacks
7/22/08 - Diet: Pureed and Nectar Liquids and snacks

- Dietician Assessment:
7/10/08 - Diet Order: Pureed total assist with meals - and Nectar Liquids. No new labs since 11/07.

- Dietary Progress Notes:
7/14/08 - Current Diet: Pureed with Nectar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8 Liquids. - Nursing Summaries: 5/1/08 - Current Diet: Pureed 6/19/08 - Current Diet: Pureed 7/22/08 - Current Diet: Pureed 8/18/08 - Current Diet: Pureed - Speech Therapy: 7/14/08 - Diet and Liquid: Pureed/Nectar - In the afternoon on 8/21/08, the Dietary Manager printed the Resident's meal ticket. It listed his diet as Pureed/Nectar Liquids. Interview - In the afternoon on 8/21/08, the Dietary Manager confirmed a Physician's order was needed for Nectar Liquid. She indicated the Speech Therapist making the diet recommendation will call the Physician and receive a telephone order. Observation At 4:30 PM on 8/21/08 the Resident was observed to have nectar thick liquid with his dinner meal.	F 309		
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		10/7/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 9 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation, the facility failed to limit significant weight loss in 1 of 33 residents (#3). Findings include: Resident #3 Resident #3 was a 60 year old male admitted on 01/30/08 with diagnoses including Dysphagia, Adult Failure To Thrive, Hypoalbuminemia, Malnutrition, Cerebrovascular Accident, Speech Disturbance, Coronary Disease, Pneumonia, Gastrostomy Tube, and Depression. Record Review Initial physician orders indicated a diet of Fibersource HN at 60 milliliters (ml) per hour with 180 ml of water every 6 hours. The rate was changed to 80 ml per hour for 18 hours with 250 ml of water every 8 hours on 01/31/08. The facility maintained these same rates between 01/31/08 and 08/22/08. Section K of the admission Minimum Data Set (MDS) assessment, dated 02/05/08, indicated the resident had chewing and swallowing problems and weighed 186 pounds. The MDS identified the Resident Assessment Protocol for feeding tubes and dehydration/fluid maintenance as areas for the resident's care plan development. The	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 10	F 325		

resident's care plan was initiated on 02/08/08, and reviewed on 05/08/08 and 08/08/08. Between 02/08/08 and 08/21/08, the facility did not modify any approaches/interventions in addressing the resident's feeding tube and dehydration/fluid maintenance. All care plan copies contained the same, unmodified care plan approaches/interventions.

On the facility's initial comprehensive nutritional assessment dated 01/31/08, the facility indicated the resident's ideal body weight range to be between 149-183 pounds with a median weight of 166 pounds. The assessment indicated weight loss was unavoidable due to the resident's diagnoses of Dysphagia and Failure To Thrive. However, four of the eight weekly weight summaries in June and July 2008 indicated unexpected weight loss. The facility care planned the resident for Dysphagia on 04/18/08, and reviewed it on 05/18/08. The care plan did not indicate whether or not the Dysphagia problem was resolved and the facility failed to modify or update the care plan after 05/18/08.

Section K of the quarterly MDS dated 07/23/08, indicated chewing and swallowing remained problems and the resident weighed 165 pounds. Between the resident's admission date of 01/30/08 and 08/22/08, the facility did not care plan the admission diagnoses Adult Failure To Thrive and Hypoalbuminemia. On page three of this same admission assessment, the dietitian did not list any problems, measurable goals, and interventions to address any of the resident's related nutritional diagnoses.

The facility's monthly enteral feeding assessment dated 05/02/08, indicated the resident was on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 11	F 325		

pureed diet with nectar thick liquids as of 04/24/08. Between 04/24/08 and 08/22/08, the resident continued with this same diet plan. Section G of the MDS dated 02/05/08 and 07/23/08, indicated the resident was coded a "4" for eating self performance, meaning completely dependent. Section G of the same MDS assessments coded the resident as a "2" for eating support, meaning one person physical assist.

The certified nursing assistant flow sheets:
For April 2008 recorded only six meal intake percentages and four shifts of coded self performance and staff support out of six days remaining in April;
For May 2008, thirty-three shifts of coded self performance and staff support and only fourteen meal intake percentages were recorded out of thirty-one days;
For June 2008, fifteen shifts of coded self performance and staff support and thirty-eight meal percentages were recorded out of thirty days; and
For July 2008, twelve shifts of coded self performance and staff support and six meal intake percentages were recorded out of thirty-one days.

The chart lacked any other indication the resident had assistance with oral intake as coded by the MDS or the resident's intake percentage. The facility did not consistently monitor/record the resident's self performance and staff support for oral nutrition and the percentages of meals the resident ate between 04/24/08, when his oral diet began, and 07/31/08.

For the shifts and days without codes and meal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12	F 325		

intake percentages, the facility documented "GT" for gastrostomy tube. The resident's care plan approach #9 for feeding indicated "full assist with all meals in (eats in his room)." The facility did not consistently monitor/record whether or not the resident received this assistance. The dietician did not assess/record the resident's food preferences during the same period. According to the facility's policy on dietary assessment, the dietitian is responsible for including food preferences in any dietary assessment. According to the resident's monthly weight record, the resident dropped 14 pounds between 05/01/08 (when he weighed 185) and 08/01/08 (when he weighed 171).

Part two of the facility's weight loss monitoring policy dated 10/05/07, indicated the dietitian, dietician assistant, and assistant director of nursing would monitor monthly and weekly weights with discrepancies requiring re-weights. The resident's weight record indicated the following dates and weights for each:

02/03/08 186 pounds
02/10/08 181 pounds
02/17/08 178 pounds
03/01/08 183 pounds
04/02/08 183 pounds
05/01/08 185 pounds
06/01/08 170 pounds
06/03/08 170 pounds
06/08/08 178 pounds
06/15/08 169 pounds
06/22/08 168 pounds
07/01/08 178 pounds
07/06/08 167 pounds
07/13/08 165 pounds
08/21/08 160 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 13	F 325		

The facility recorded two re-weights: One for 06/08/08 and another for 07/01/08. Those re-weights were 167 and 164 respectively.

Part three of the facility's weight loss monitoring policy indicated the facility would note interventions on its weekly weight reports. The facility did weekly weight summaries eight times in June and July 2008 (between 06/06/08 and 07/30/08). The summaries listed continuing weekly weights as the only intervention. The summaries for 06/11/08, 06/18/08, 07/23/08, and 07/30/08 indicated unexpected weight loss. The facility did nutritional recommendations sheets eleven times between 06/06/08 and 08/20/08. The recommendations listed "weekly weights" as the only intervention. The recommendation sheet, dated 08/13/08, failed to address Resident #3 altogether. The recommendation sheet, dated 08/20/08, indicated a re-weight, and the resident weighed 160 the next morning on 08/21/08, another five pound loss since 07/13/08.

Part four of the facility's weight loss monitoring policy indicated the facility would notify the doctor "if interventions aren't working for other ideas." The facility notified the Advance Nurse Practitioner (ANP) in a document dated 06/18/08, noting a 16 pound weight loss between 05/01/08 and 06/15/08. The document was signed (by either the physician or ANP, undiscernible handwriting) and lacked any additional interventions.

Part five of the facility's weight loss monitoring policy indicated the facility would "continue to monitor till weights have been maintained for 4-5 weeks." The facility did so, but the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 14	F 325		

dropped another nine pounds between 06/15/08 and 08/21/08. The facility's policy failed to address what should be done when re-weights or continued weekly weights demonstrate continued weight loss.

Care plan approach #4 indicated to check for tube feeding residuals. The chart lacked documentation of residuals for the resident. The facility charted the resident as tolerating the tube feeding well between 01/31/08 and 08/14/08 without exception. The tube feeding rate did not change between 01/31/08 and 08/22/08.

The facility did not assess and document the cause of the unplanned 25 pound weight loss documented between 05/01/08 and 08/21/08. The facility did not follow its own weight loss policy consistently. The facility did not care plan the related nutritional diagnoses and weight fluctuation for this resident. The facility did not alternately modify and evaluate the approaches/interventions it used for the nutritional/feeding care plan. The facility did not consistently monitor/record the resident's feeding performance, feeding support received, and meal percentage intake. The facility did not contact the physician, and the advanced nurse practitioner did not suggest any new interventions on 06/18/08 when notified regarding the resident weight loss. (Note: The physician/ANP did order boost pudding three times per day between meals as a dietary supplement at 5:15 PM on 08/21/08 after interviews with Employee #6 and #2).

Interview

On 08/21/08, at 3:15 PM, Employee #6 indicated the facility initiated weekly weights on 06/06/08.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 15	F 325		

The facility continued weekly weights. She indicated the resident's meal intake decreased from 40% to 10% as of 07/09/08 and increased from 10% to 40% as of 07/30/08. [However, the July 2008 certified nursing assistant flow sheet indicated the meal intake for Resident #3 was 40% only once]. Employee #6 indicated the facility remained in verbal contact with the advanced nurse practitioner (ANP) on a weekly basis, but the facility never notified the doctor because it was easier to notify the ANP. The facility informed the advanced nurse practitioner on 06/18/08, in writing, and the facility received no new orders. Employee #6 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #6 indicated none were written. Employee #6 indicated the facility held weekly weight summary meetings with Employees #2, #5, and #6. Employee #6 indicated approaches were limited to re-weights of spurious weights and continuing weekly weights.

On 08/21/08, at 4:30 PM, Employee #2 indicated Employees #2, #5, and #6 met weekly regarding weekly weight summaries for residents with weight loss. Employee #2 was shown the facility's weight loss policy and the weight record for Resident #3. Employee #2 agreed the facility's policy was to re-weigh residents with questionable weight loss and the facility should have re-weighed Resident #3 after a 15 pound weight loss on 06/01/08. Employee #2 browsed through the weekly weight summaries and the feeding care plan #5 for Resident #3 and indicated the following: The approaches for Resident #3 were limited to weekly weights, pureed diet, and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 16	F 325		

ANP did not offer suggestions when contacted on 06/18/08. Employee #2 indicated Resident #3's meal intake increased to 40% as of 06/25/08 and as of 07/30/08. [However, both the June 2008 and July 2008 certified nursing assistant flow sheets indicated the meal intake for Resident #3 was 40% once in each month]. Employee #2 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #2 indicated none were written.

On 08/22/08, between 9:00 AM and 9:20 AM, Employee #5 indicated Resident #3 weighed 186 pounds at admission (on 02/03/08) and weighed 165 pounds on 07/23/08 and 162 pounds on 08/22/08. Employee #5 indicated other approaches/interventions, such as increasing the tube feeding, were not considered because Resident #3 was still within the established ideal body weight range between 149 and 183 pounds, although now below the median of 166. There was also a concern of increasing residuals [even though no residuals were ever documented in the chart]. Employee #5 indicated Employees #2, #5, and #6 met to revise approaches during weekly weight summary meetings. Employee #5 reviewed care plan problem #5 (tube feeding) and when interviewed regarding any new approaches/interventions for feeding Resident #3 on the care plan for problem #5 between 02/08/08 and 08/21/08, Employee #5 indicated none were written. Employee #5 indicated approaches/interventions should correspond to problems and that it was her mistake and her responsibility for not listing new approaches/interventions, revising them, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 17 writing new ones. Observation On 08/22/08 between 8:00 AM and 8:15 AM, the facility re-weighed Resident #3, and the facility documented the resident's weight as 160 pounds (on 08/21/08).	F 325		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain its medication error rate at less than five percent. Findings include: Five errors with 46 opportunities for error resulted in an error rate of 10.8%. Resident #32 was originally admitted to the facility on 04/27/00, and readmitted on 02/08/02, with diagnoses of Shortness of Breath, Hemiplegia Unspecified, Gastrointestinal Bleed, Leukocytosis, Urinary Tract Infection, Cardiovascular Accident, Hyperkalemia, Hypophosphatemia, Hypomagnesemia, Hypertension, Aphasia, Cardiomegaly, Atrial Fibrillation, Gastrostomy Tube, Below Elbow Amputee, and Aphagia. Observation	F 332		10/7/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 18	F 332		

On 08/19/08, at 2:00 PM, Employee #7 was observed administering .75 milliliters (ml) of Methadone via gastric tube to Resident #32. Employee #7 indicated the medication container was empty and only .75 ml of Methadone was available. The original physician order dated 06/05/08 indicated Methadone 15 milligrams by gastric tube every 8 hours. On 09/04/08 at 10:50 AM, an interview with Jennifer, a Spectrum pharmacist, indicated Resident #32's order was 15 milligrams of Methadone, the dosage concentration was 10 to 1, and a 15 milligram dose was equivalent to 1.5 ml. Employee #7 indicated on the reverse side of the August 2008 medication administration record (MAR) only .75 ml of Methadone was left in the container to administer to Resident #32.

Resident #28 was admitted to the facility on 08/08/08, with diagnoses of Debility, Seizure Disorder, Hydronephrosis, Hypertension, Dementia, Cardiovascular Disease, Anemia, Syncope, Coronary Disease, Osteoarthritis, Acute Myocardial Infarction, and Constipation.

On 08/20/08, at 8:30 AM, Employee #8 was observed and failed to administer the morning dose of Metoprolol 25 milligrams. A detailed search of the medication cart failed to reveal Metoprolol for Resident #28. The original physician order dated 08/18/08, indicated Metoprolol 25 milligrams twice daily. Between 8:25 AM and 8:30 AM, Employee #8 was observed initialing and circling her initial for the morning dose of Metoprolol scheduled at 8:00 AM on 08/20/08. Employee #8 indicated she would check with the pharmacy for delivery. (Note: According to the facility's Pharmaceutical Service Manual from Spectrum Pharmacy (revised April

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 19	F 332		

2005 under directive #12 on page 83), "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time initial and circle initials on the front of the MAR in the space provided for that dosage administration.") Employee #8 failed to provide a definitive answer regarding the delivery of the medication.

On 08/20/08, at 3:45 PM, Employee #9 indicated the facility received three doses of Metoprolol, and Employee #9 gave the last dose on 08/19/08 at 8:00 PM. According to the facility's Pharmaceutical Service Manual dated 07/04 under the section entitled Medication Delivery System on page 25, "new drug orders should be received and available for administration within 24 hours of the time the order is transmitted to the pharmacy." The original physician order dated 08/18/08 was noted the same day by the nurse.

On 08/20/08, at 8:30 PM, Employee #8 failed to administer the correct doses of Calcium and Vitamin C. The original physician orders dated 08/08/08 indicated Calcium with Vitamin D 500 milligrams twice daily and Vitamin C 250 milligrams daily. Between 8:25 AM and 8:30 AM, observation of Employee #8 revealed administration of 600 milligrams of Calcium and 500 milligrams of Vitamin C to Resident #28. The August 2008 MAR indicated a handwritten #6 imposed over the #5 for 600 milligrams of Calcium instead of 500. Employee #8 was shown the original order of Calcium 500 milligrams. The chart, copied on the morning of 08/22/08 by Employee #10, lacked a physician order changing Calcium from 500 to 600 milligrams at any point in time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 20 Resident #29 was admitted to the facility on 07/31/08 with diagnoses of Bilateral Ankle Sprain, Hypertension, Rheumatoid Arthritis, and Insomnia. An original physician order dated 07/31/08, indicated Protonix 40 milligrams daily. On 08/20/08, at 9:00 AM, Employee #8 was observed and failed to administer the daily dose of Protonix 40 milligrams. A detailed search of the medication cart failed to reveal Protonix for Resident #29. Employee #8 was observed initialing and circling her initials for the morning dose of Protonix scheduled at 8:00 AM on 08/20/08. (Note: According to the facility's Pharmaceutical Service Manual from Spectrum Pharmacy (revised April 2005 under directive #12 on page 83), "if a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time initial and circle initials on the front of the MAR in the space provided for that dosage administration.") On the reverse side of the August 2008 MAR, Employee #8 indicated the pharmacy was contacted regarding delivering Protonix, but she could not indicate a delivery time. Employee #8 indicated she had to circle her initials on the MAR when medications weren't given.	F 332		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		10/7/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 21	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure that perishable foods were stored under sanitary conditions.

Findings include:

Observation

At 10:00 AM on 8/21/08, multiple single serving cartons of milk were stored in the small refrigerator adjacent to the ice machine in the kitchen. Three cartons of chocolate milk had an expiration date of 8/14/08. One carton of milk had an expiration date of 8/13/08.

At 10:10 AM on 8/21/08, there was a single serving container of yogurt stored on the top shelf which had an expiration date of 8/11/08.

On 8/21/08, from 12:00 PM until 12:45 PM, multiple single serving milk cartons stored on a rectangular table in the Dining Room without refrigeration. The milk temperature was 60 degrees Fahrenheit at 12:20 PM.

Interview

On 8/20/08, in the afternoon during the Group Interview, there was a group consensus that the milk served at the evening meal "tasted sour."

On 8/21/08 in the afternoon, the Dietary Manager indicated they were aware of residents complaining of sour milk. The Dietary Manager further indicated that the cause of the sour milk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295070	A. BUILDING _____ B. WING _____	08/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PLAZA REGENCY AT SUN MOUNTAIN	6021 W. CHEYENNE AVE. LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 22 was due to the distributor's lack of safe temperature storage prior to the delivery to the facility.	F 371		